

CT patient safety questionnaire

Last name, given name:

Date of birth:

Weight in kg:

Telephone number: _____

Which part of your body shall be examined today?

left right

What is troubling you and where does it hurt?

Did or do you have any tumor?

yes no

Have you had an operation on this part of your body? If so, when and what was done?

Do you have any allergies, especially to iodine?

yes no

Do you have a hyperthyroidism?

yes no

Has a diabetes mellitus been diagnosed?

yes no

Are you suffering from any chronic disease?

yes no

Are you suffering from a restricted kidney function?

yes no

Are you currently under medication?

If so, what do you ingest?

Female patients: Could you be pregnant?

yes no

In case an injection of contrast agent may aid in the evaluation of the study, do you agree with it? The radiologist will inform you about the risks and benefits.

yes no

Have you ever suffered from a contrast agent intolerance during an MRI examination?

yes no

The technologists and radiologists will gladly answer any further question you may have. Please confirm your consent with the planned exam by signing below.

Date and signature